

emailed validation  
letter 1/31/11

**Application for License to  
Operate a Long-term Care Facility**

For Office Use Only  
Received 12-29-10  
Amount \$1920.-

Ch # 8113220

**I. IDENTIFICATION**

Name GGNSC Stanford LLC, d/b/a Golden LivingCenter - Stanford  
Address 105 Harmon Heights  
City/County/Zip Stanford, KY 40484  
Telephone number 606-365-2141  
Administrator Timothy Peek  
Date facility operation began at current address   
Date facility began operation under current owner 04/01/2006

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u></u>	<u></u>
Nursing Home	<u></u>	<u></u>
Nursing Facility	<u>128</u>	<u>128</u>
Intermediate Care	<u></u>	<u></u>
ICF/MR	<u></u>	<u></u>
Personal Care	<u></u>	<u></u>

**II. CONTROL (check one in each column)**

State County City Private	Profit Nonprofit	Individual Partnership Corporation
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**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

See Attached Officers and Directors Listing as of December 28, 2010

(OVER)

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If facility owned or leased by a corporation, complete the following:

Name of corporation

Address of corporation

President or Chairman

Vice President

Secretary

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

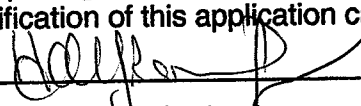
If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent
GGNSC Equity Holdings LLC
1000 Fianna Way
Fort Smith, AR 72919

Management Company
N/A

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

  
\_\_\_\_\_  
Signature of authorized representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)

## **Officers and Directors Report with Title**

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**As of 12/28/2010**

### **GGNSC Stanford LLC**

#### **Directors**

<b>Name</b>	<b>Title</b>
Herschel B Sedoris	Director
Jennifer Kenton	Independent Director
Gretchen Olive	Independent Director

#### **Officers**

	<b>Name</b>	<b>Title</b>
<b>Executive Officer</b>	Herschel B Sedoris	President

	<b>Name</b>	<b>Title</b>
<b>General Officer</b>	Kevin M Roberts	Senior Vice President
	Tina C Chavis	Vice President
	Nicholas R Finn	Vice President
	Larry N Joseph	Vice President
	Salvatore F Salamone	Vice President
	James P Zoesch	Vice President
	Holly Rasmussen-Jones	Secretary
	Ann Truitt	Treasurer & Assistant Secretary
	Holly L Sutton	Assistant Secretary
	Greg D Swartz	Assistant Secretary
	Roberta G Williams	Assistant Secretary

**Address for Notification:**  
**1000 Fianna Way**  
**Fort Smith, AR 72919**